

Prior Authorization

[Refer to WAC 388-531-0200]

The prior authorization process only applies to covered services; and is subject to client eligibility and program limitations. Not all categories of eligibility receive all services. **For example:** Therapies are not covered under the Family Planning Only Program. Prior authorization does not guarantee payment.

MAA's prior authorization requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written or fax prior authorization (PA); and
- Expedited prior authorization (EPA).

These authorization procedures do not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care. [Refer to WAC 388-502-0120]

Limitation Extensions (LE)

What is an LE?

LE is an authorization process for medically necessary units of service that exceed the benefit or program allowance. The provider must verify medical necessity for the additional units of service. The medical record documentation must support the medical necessity and be available to MAA upon request. The allowed units of service are published in MAA's billing instructions and Washington Administrative Code (WAC).

How do I get LE authorization?

LE authorizations are obtained by using the EPA process. Refer to the EPA section (page I.5) for criteria. If the EPA process is not applicable, limitation extensions may be obtained using the written/fax prior authorization process (see below).

Written/Fax Prior Authorization

What is written/fax PA?

Written/fax prior authorization is an authorization process available to providers when expedited prior authorization criteria has not been established.

Which services require written/fax PA?

Services requiring written/fax PA are noted in WAC, MAA's billing instructions, and/or the fee schedule.

EXAMPLES of services that require written/fax PA include, but are not limited to:

Code(s)	Procedure
54416-54417	Repair of Penile Implant
55873	Cryosurgical Ablation of the Prostate
61885, 61886, 64573 and 64585	Vagus Nerve Stimulator Insertion, Removal, or Revision
66930	Cochlear Implantation
67909	Reduction of Overcorrection of Ptosis
69714-69718	Osseointegrated Implants
G0330 and G0331	Tumor imaging (PET)
88380	Microdissection
95965-95967	Magnetoencephalography (MEG)
99221-99223	Inpatient Acute PM&R
J2020	Linezolid injection
J2940	Somatrem injection
J2941	Somatropin injection
J7340	Metabolic active D/E tissue
S0093	Morphine 500 mg
0010T	New technology CPT Category III codes

How do I obtain written/fax PA?

Send a completed "Fax/Written Request Basic Information" form [DSHS # 13-756] to:

MAA – Division of Medical Management
 Attn: Provider Request/Client Notification Unit
 PO Box 45506
 Olympia, WA 98504-5506
 FAX: (360) 586-1471

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How do I obtain authorization for PET scans?

Send a completed “PET Scan Information” form [DSHS # 13-757] to:

MAA – Division of Medical Management
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care.

- MAA’s intent for the EPA process is to establish prior authorization criteria and identify these criteria with specific codes, enabling providers to create an “EPA” number when appropriate. MAA denies claims submitted without the appropriate EPA number related to the specific service. MAA also denies claims submitted without a required EPA number, when available.

How is an EPA number created and billed?

To bill MAA for a service that meets the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits of the EPA number must be related to the client-specific service. Enter the entire 9-digit EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* section when billing electronically.

Example: The 9-digit authorization number for a brain MRI in a client with suspected brain tumor and new onset of unexplained seizures would be **870000303** (**870000** = first six digits of all EPA numbers, **303** = last three digits of an EPA number indicating that the specific criteria is met).



Note: Written/fax PA is required when there is no option to create an EPA number.

Expedited Prior Authorization Guidelines

Documentation

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon MAA's request. If MAA determines the documentation does not support the EPA criteria being met, the claim will be denied.

Which services require EPA?

EPA is required for services noted in WAC, MAA's billing instructions, and/or fee schedules as needing EPA.

Examples of services requiring EPA:

- **Hysterectomies** (CPT: 51925, 58150-58285, 58545, 58546, 58550, 59525)
Note: CPT codes 58152 and 58267 must meet guidelines for both hysterectomies and bladder repair.

Exceptions: MAA does not require EPA for clients 46 years of age and older; **or** clients that have been diagnosed with cancer(s) of the female reproductive organs (ICD-9-CM: 179-184.9, 198.6, 198.82, 233.1-233.3, 236.0-236.3, and 239.5).
- **Bladder Repairs** (CPT: 51840-51845, 57288-57289, 58152, and 58267)
Note: Bladder repairs are only allowed for clients with a diagnosis of stress urinary incontinence (ICD-9-CM: 625.6, 788.30-788.39)
- **Reduction Mammoplasties** (CPT: 19318)
Note: Reduction Mammoplasties are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.
- **Mastectomies for Gynecomastia** (CPT: 19140)
Note: Mastectomies for Gynecomastia are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.
- **Visual Exams, Dispensing and Fitting Fees, Frames, Glasses, and Lenses**
When in excess of MAA's established limitations.
- **Blepharoplasties** (CPT: 15822, 15823, 67901-67908)
- **Strabismus Surgery** (CPT: 67311-67340) only for clients 18 years of age and older.

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Physician-Related Services

- **Physical and Occupational Therapy**
When in excess of MAA's established limitations.
- **Outpatient PET Scans**
Exception: HCPCS codes G0330 and G0331 require written/fax prior authorization.
- **Outpatient MRIs and MRAs**
- **Orthotics. Exception:** HCPCS codes L3170, L3230, L3340, L3350, L3360, L3400, L3410, L3420, L4360, L4386, and L5507 require written/ fax prior authorization.
- **Inpatient Medical Admissions (CPT: 99221-99223)**
MAA requires EPA:
 - ✓ For clients seven years of age and older; and
 - ✓ When both the admitting and discharge (final/principle) diagnoses are on the list below:

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789.00-789.09
Back Pain	724.00-724.6, 724.8-724.9, 846.0-847.9
Cellulitis	681.00-681.9, 682.0, 682.2-682.9
Chronic pancreatitis	577.1
Constipation	560.30, 560.39, 564.00-564.9
Dehydration; Disorders of Electrolyte Imbalance	276.0-276.6, 276.8-276.9
Gastritis/Gastroenteritis	535.00-535.61, 558.1-558.9
Headache	784.0
Malaise & Fatigue	780.71-780.79
Migraine Headache	346.00-346.91
Nausea/vomiting	536.2; 787.01-787.03
Painful Respiration	786.52
Related general symptoms	780.01, 780.4, and 780.91-780.99
Respiratory abnormality	786.09

An outpatient/observation admission does not require prior authorization – use CPT codes 99218-99220 for an outpatient/observation admission and 99217 for an outpatient/observation discharge; or 99234-99236 for an outpatient/observation admission/discharge on the same calendar date.

MAA does not require EPA for inpatient medical admissions for clients six years of age and younger. However, these admissions must be medically appropriate in accordance with MAA's established criteria.

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(Revised July 2005)

- I.5 -

Prior Authorization

Memo 05-59 MAA

**Washington State
Expedited Prior Authorization Criteria Coding List**

Code	Criteria	Code	Criteria
Abdominal Hysterectomy		Vaginal Hysterectomy	
CPT: 58150, 58180, 58200, 58210		CPT: 58270-58285, 58550-58554, 58260-58263, 58290, 58291-58292, and 58294	
101	Diagnosis of <i>abnormal uterine bleeding</i> in a client 30 years of age or older with <i>two or more</i> of the following conditions: <ul style="list-style-type: none"> 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months; 2) Documented hct of <30 or hgb <10; or 3) Documented failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months). 	111	Diagnosis of <i>abnormal uterine bleeding</i> in a client 30 years of age or older with <i>two or more</i> of the following conditions: <ul style="list-style-type: none"> 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months; 2) Documented hct of < 30 or hgb < 10; or 3) Documentation of failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months).
102	Diagnosis of <i>fibroids</i> for any <i>one</i> of the following indications in a client 30 years of age or older: <ul style="list-style-type: none"> 1) Myomata associated with uterus greater than 12 weeks or 10cm in size; 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10; or 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams. 	112	Diagnosis of <i>fibroids</i> for any <i>one</i> of the following indications in a client 30 years of age or older: <ul style="list-style-type: none"> 1) Myomata associated with uterus greater than 12 weeks or 10cm in size; 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct < 30 or hgb < 10; or 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
103	Diagnosis of <i>symptomatic endometriosis</i> in a client 30 years of age or older with the following: <ul style="list-style-type: none"> 1) Significant findings per laproscope; <i>and</i> 2) Unresponsiveness to 3 months of hormone therapy or cauterization. 	113	Diagnosis of <i>symptomatic endometriosis</i> in a client 30 years of age or older with the following: <ul style="list-style-type: none"> 1) Significant findings per laproscope; <i>and</i> 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
104	Diagnosis of <i>chronic advanced pelvic inflammatory disease</i> in a client 30 years of age or older with infection refractory to multiple trials of antibiotics	114	Diagnosis of <i>chronic advanced pelvic inflammatory disease</i> in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

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Code	Criteria	Code	Criteria
115	Diagnosis of <i>symptomatic pelvic relaxation</i> (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).	226	<i>Hysterectomy not requiring authorization</i> and <i>Stress Urinary Incontinence</i> meeting criteria 201.
Bladder Neck Suspension		Other Hysterectomies and/or Bladder Repairs with Diagnosis of 625.6 or 788.30-788.39	
CPT: 51840-51845, 57288-57289		CPT: 51840-51845, 51925, 57288-57289, 58150, 58152, 58180, 58200, 58210, 58240, 58260-58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550-58554, and 59525	
201	Diagnosis of <i>stress urinary incontinence</i> with all of the following: <ol style="list-style-type: none"> 1) Documented urinary leakage severe enough to cause the client to be pad dependent; <i>and</i> 2) Surgically sterile or past child bearing years; <i>and</i> 3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; <i>and</i> 4) Urodynamics showing loss of ureterovesical angle or physical exam showing weak bladder neck; <i>and</i> 5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery. 	230	Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.
Hysterectomy with Colopouretrocystopexy		Reduction Mammoplasties/ Mastectomy for Gynecomastia	
CPT: 51925, 58152, 58267, and 58293		CPT: 19318, 19140 DX: 611.1 and 611.9 only	
221	Diagnosis of <i>Abnormal uterine bleeding and Stress Urinary Incontinence</i> -meeting criteria 101 or 111 and 201.	241	Diagnosis for <i>hypertrophy of the breast</i> with: <ol style="list-style-type: none"> 1) Photographs in client's chart, <i>and</i> 2) Documented medical necessity including: <ol style="list-style-type: none"> a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, <i>and</i> b) Conservative treatment not effective; <i>and</i> 3) Abnormally large breasts in relation to body size with shoulder grooves, <i>and</i> 4) Within 20% of ideal body weight, <i>and</i> 5) Verification of minimum removal of 500 grams of tissue from each breast.
222	Diagnosis of <i>Fibroids and Stress Urinary Incontinence</i> -meeting criteria 102 or 112 and 201.	242	Diagnosis for <u><i>gynecomastia</i></u> : <ol style="list-style-type: none"> 1) Pictures in clients' chart, <i>and</i> 2) Persistent tenderness and pain, <i>and</i> 3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.
223	Diagnosis of <i>Symptomatic Endometriosis and Stress Urinary Incontinence</i> -meeting criteria 103 or 113 and 201.		
224	Diagnosis of <i>Chronic Pelvic Inflammatory Disease and Stress Urinary Incontinence</i> - meeting criteria 104 and 114.		
225	Diagnosis of <i>Symptomatic Pelvic Relaxation and Stress Urinary Incontinence</i> - meeting criteria 115 and 201.		

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(Revised July 2005)

- I.7 -

Prior Authorization

Memo 05-59 MAA

Physician-Related Services

Code	Criteria	Code	Criteria
Other Reduction Mammoplasties/ Mastectomy for Gynecomastia With Diagnosis of 611.1 Or 611.9			
250	Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.	304	<i>Follow up of brain tumor</i> if done at: <ol style="list-style-type: none"> 1) Three months from the date of last MRI/MRA and in the first two years of diagnosis in any of the following cases: <ol style="list-style-type: none"> a) Tumor is currently being treated; b) Post treatment; c) With documented changes in tumor size; <i>or</i> 2) Six months from the date of last MRI/MRA and in the second to fifth years of diagnosis; <i>or</i> 3) One year from the date of last MRI/MRA in the sixth to tenth year of diagnosis; <i>or</i> 4) Symptoms of recurrence in a client that would be treated aggressively.
Brain MRI/MRA CPT: 70544-70546, 70551-70559			
301	Suspected diagnosis of <i>acoustic neuroma</i> if one of the following: <ol style="list-style-type: none"> 1) Unilateral sensorineural hearing loss per audiogram; <i>or</i> 2) Decreased discrimination score that is out of proportion to amount of hearing loss per ENT evaluation; <u>or</u> 3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above. 	305	Suspected diagnosis of <i>multiple sclerosis</i> with <i>three or more</i> of the following objective findings: <ol style="list-style-type: none"> 1) Progressive weakness or decreased sensation in extremities; 2) Difficulty word finding; 3) Diplopia; 4) Vertigo or vertigo nystagmus; 5) Optic neuritis; 6) Facial weakness; <i>or</i> 7) Positive Lhermitte's sign.
302	Suspected diagnosis of <i>pituitary tumor</i> with any <i>two</i> of the following: <ol style="list-style-type: none"> 1) Galactorrhea; 2) Pre menopausal amenorrhea; 3) Elevated prolactin level (females must have negative pregnancy test); <i>or</i> 4) Positive or inconclusive computed tomography and one of the above with a need for clearer definition 	Note to 305: Only for initial diagnosis, not as a follow-up.	
303	Suspected diagnosis of <i>brain tumor</i> with any one of the following: <ol style="list-style-type: none"> 1) Unexplained new onset seizure; 2) Objective evidence of increased intracranial pressure; <i>or</i> 3) Positive or inconclusive computed tomography with a need for clearer definition, and <i>one</i> of the above. 	306	Suspected diagnosis of <i>toxoplasmosis versus lymphoma versus progressive multifocal leukoencephalopathy</i> in an HIV positive client with: <ol style="list-style-type: none"> 1) Central nervous system changes in a client that would be aggressively treated; and 2) Positive or inconclusive computed tomography with a need for clearer definition in a client that would be aggressively treated.
		307	Diagnosis of <i>breast cancer</i> for staging as part of PSCT or BMT protocol.

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Physician-Related Services

Code	Criteria	Code	Criteria
308	Suspected diagnosis of <i>seizure disorder</i> with unexplained onset of seizures.	4)	Upper extremity muscle atrophy;
309	Diagnostic evidence of <i>refractory seizures</i> , as part of preoperative work up.	5)	Hyperreflexia;
310	Suspected diagnosis of <i>residual tumor or residual vascular malformation</i>	6)	Positive babinski in non-infant; or
Lumbar MRI/MRA		7)	Studies showing definitive nerve root compression, and ruling out carpal tunnel syndrome.
CPT: 72148, 72149, 72158		Note to 321: Carpal tunnel syndrome must be ruled out prior to cervical MRI when symptoms indicate possible carpal tunnel syndrome.	
311	Suspected diagnosis of <i>Herniated Nucleus Pulposus or Tumor</i> in a surgical candidate with <u>two</u> or more of the following objective findings:	322	Suspected diagnosis of <i>tumor or abscess</i> with a bone scan or x-ray suspicious for same.
	1) New onset of bowel or bladder incontinence not related to known diagnosis;	Thoracic MRI/MRA	
	2) Asymetric or bilaterally absent tendon reflexes in the lower extremity (patella/achilles);	CPT: 72146, 72147, 72157	
	3) Visible atrophy of key muscle groups of lower extremities;	331	Suspected diagnosis of <i>tumor or abscess</i> ;
	4) Decreased sensation in a dermatomal pattern not previously attributed to another diagnosis;		1) With a bone scan or x-ray suspicious for same, <i>or</i>
	5) Significant weakness of key muscle groups of either or both lower extremity; or		2) Evidence of myelopathy, such as hyperreflexia, positive babinski in a non-infant, ataxia, etc.
	6) Positive study indicating definitive nerve root compression.	Pelvic MRI/MRA	
312	Suspected diagnosis of <i>tumor or abscess</i> with a bone scan or x-ray suspicious for same.	CPT: 72195-72197	
Cervical MRI/MRA		341	Suspected diagnosis of <i>avascular necrosis</i> with:
CPT: 72141, 72142, 72156			1) Pain in the hip radiating to the knee; <i>and</i>
321	Suspected <i>herniated nucleus pulposa or tumor</i> with <i>two or more</i> of the following objective findings:		2) A history of one of the following:
	1) Decreased tricep, bicep, or brachial radialis reflex;		a) Previous trauma;
	2) Decreased sensation in upper extremities in a dermatomal distribution;		b) Intracapsular fractures;
	3) Decreased muscle strength of upper extremities and limitation of movement;		c) Alcoholism;
			d) High dose steroid use;
			e) Air embolism from diving, or
			f) Hemoglobinopathies
		342	Suspected diagnosis of <i>tumor or abscess</i> with a bone scan or x-ray suspicious for same.

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(Revised July 2005)

- I.9 -

Prior Authorization

Memo 05-59 MAA

Code	Criteria	Code	Criteria
Knee MRI/MRA CPT: 73721-73723		Upper Extremity MRI/MRA CPT: 73218-73223	
351	Suspected <i>anterior cruciate ligament tear</i> when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <i>three</i> of the following: <ol style="list-style-type: none"> 1) History of hyperextension injury with immediate swelling, and complaints of giving way or buckling; <i>or</i> 2) Four or more weeks of conservative care; <i>or</i> 3) Current exam with the following findings: hemarthrosis and/or positive Lockman's and/or positive pivot shift; <i>or</i> 4) MRI is necessary to choose treatment option(s). 	361	Suspected diagnosis of <i>tumor or abscess</i> with a bone scan or x-ray suspicious for same.
352		Lower Extremity MRI/MRA CPT: 73718-73723, -73723, 73725	
Suspected <i>posterior cruciate ligament tear</i> when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <i>two</i> of the following: <ol style="list-style-type: none"> 1) History of direct blow to anterior tibia or forced hyperflexion; <i>or</i> 2) Four or more weeks of conservative care; <i>or</i> 3) Current clinical with <i>one or more</i> positive findings: positive drawers, test positive tibial sag. 		371	
353		Abdominal MRI/MRA CPT: 74181-74183, 74185	
Suspected <i>meniscal tear</i> when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <u>two</u> of the following: <ol style="list-style-type: none"> 1) History of twisting injury with subsequent catching, locking, and swelling; <i>or</i> 2) Four or more weeks of conservative care; <i>or</i> 3) <i>One or more</i> of the following exam findings: joint line tenderness, positive McMurrays. 		381	
		Other MRI/MRA All other covered MRI/MRA	
		390	
		MRIs/MRAs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.	
		Note: If billing for more than one MRI/MRA <i>for the same reason</i> , use criteria code 390.	
		Note: If billing for more than one MRI/MRA <i>for different reasons</i> , build two separate expedited prior authorization numbers.	

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(Revised July 2005)

- I.10 -

Prior Authorization

Memo 05-59 MAA

Code	Criteria	Code	Criteria
<p>PET scans are covered when any one of the following PET code criteria sets are met and evidenced in the client's medical record and EPA number is assigned.</p> <p>PET Scan CPT codes: 78459, 78608, 78811-78813 DX: 793.1</p> <p>382 PET imaging regional or whole body when the client has a pulmonary nodule.</p> <p>383 PET Imaging whole body to diagnose; lung cancer (non small cell), colorectal cancer, melanoma, or lymphoma when at least one of the following is true:</p> <ol style="list-style-type: none"> 1) The PET results may assist in avoiding an invasive diagnostic procedure; or 2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. <p>PET Scans DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 201.90-202.88</p> <p>384 PET Imaging whole body for initial staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma when one of the following is true:</p> <ol style="list-style-type: none"> 1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or 2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and 3) The clinical management of the client would differ depending on the stage of the cancer identified. 		<p>PET Scans DX: 172.0-172.9, 201.90-202.88</p> <p>385 PET Imaging whole body for re-staging of; melanoma, or lymphoma after completion of treatment for one of the following reasons:</p> <ol style="list-style-type: none"> 1) To detect residual disease; or 2) To detect suspected recurrence; or 3) To determine the extent of known recurrence. <p>386 PET Imaging whole body or regional to diagnose; head and neck cancer (excluding thyroid and CNS cancers), when at least one of the following is true:</p> <ol style="list-style-type: none"> 1) The PET results may assist in avoiding an invasive diagnostic procedure; or 2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure. <p>PET Scans DX: 140.0-146.9, 148.0-148.1, 150.0-150.9, 160.0-160.8, 161.0-161.8, 173.0-173.8, 194.0-194.9, 197.3, 197.8, 198.2, 198.89</p> <p>387 PET Imaging whole body or regional for initial staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when at least one of the following is true:</p> <ol style="list-style-type: none"> 1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or 2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and 3) The clinical management of the client would differ depending on the stage of the cancer identified. 	

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(Revised July 2005)

- I.11 -

Prior Authorization

Memo 05-59 MAA

Code	Criteria	Code	Criteria
PET Scans		PET Scans	
DX: 148.0-148.9, 148.1, 160.0-160.9, 161.0-160.9, 173.0-173.9, 194.0-194.8, 197.3, 198.2, 198.89		DX: 162.0-162.9	
388	PET Imaging whole body or regional for re-staging of; head and neck cancer (excluding thyroid and CNS cancers after the completion of treatment for one of the following : 1) To detect residual disease; 2) To detect suspected recurrence; or 3) To determine the extent of known recurrence.	393	PET regional or whole body, gamma camera only, when the study is for one of the following : 1) A solitary pulmonary nodule following CT; or 2) Initial staging of pathologically diagnosed non-small cell lung cancer.
PET Scans		PET Scans	
DX: 345.11, 345.41, 345.54		DX: 174.0-174.9	
389	PET Imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures.	394	PET imaging, for breast cancer, full and partial ring, when the study is for <i>one</i> of the following: 1) Staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after, or prior to, course of treatment; or 2) Evaluation of response to treatment, performed during course of treatment.
PET Scans		PET Scans	
DX: 410.0-410.9, 414.00-414.07, 414.8		DX: 171.4, 171.9, 193, 202.01	
391	PET Imaging; metabolic assessment for myocardial viability when a SPECT study is inconclusive.	395	PET imaging, full and partial ring, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.
PET Scans		Medical Admits	
DX: 153.0-154.8, 172.0-172.9, 201.90--202.88		CPT: 99221-99223	
392	PET WhBD, gamma cameras only, for one of the following reasons: 1) Recurrence of colorectal or colorectal metastatic cancer; 2) Recurrence of melanoma or metastatic melanoma; or 3) Staging and characterization of lymphoma.	401	Diagnosis of <i>Cellulitis</i> (681.00-681.9, 682.0, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any <i>one</i> of the following: 1) Incision & drainage during admit; <i>or</i> 2) White Count greater than 10 on admit; <i>or</i> 3) Persistence or progression of fever, lymphadenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.

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Physician-Related Services

Code	Criteria	Code	Criteria
402	Diagnosis of Abdominal Pain (789.00-789.09) in a client with a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours.	408	Diagnosis of back pain (724.0-724.6, 724.8-724.9, 846.0-847.9) in a client: <ul style="list-style-type: none"> 1) Failed outpatient treatment; <i>and</i> 2) Continued use of intravenous pain medication, during the hospital stay, greater than 30 hours; <i>or</i> 3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.
403	Diagnosis of Dehydration or Electrolyte Imbalances (276.0-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.	409	Diagnosis of constipation (560.30, 560.39, 564.00-564.9) in a client: <ul style="list-style-type: none"> 1) Failed outpatient treatment; <i>or</i> 2) Recent abdominal surgery; <i>and</i> 3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.
404	Diagnosis of Nausea/Vomiting (536.2; 787.00-787.03) in a client: <ul style="list-style-type: none"> 1) With a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours; <i>or</i> 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours. 	Other Inpatient Medical Admits	
405	Diagnosis of Gastritis (535.00-535.61, 558.0-558.9) in a client: <ul style="list-style-type: none"> 1) With a Nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; <i>or</i> 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours. 	420	Inpatient medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria, for continued stay over 24 hours. Medical appropriateness must be clearly evident by the documentation in the client's medical record.
406	Diagnosis of headaches (784.0, 346.00-346.91) in a client receiving intravenous DHE, during the hospital stay, for greater than 30 hours.	Visual Exam/Refraction (Optometrists/Ophthalmologists only) CPT: 92014-92015	
407	Diagnosis of chronic pancreatitis (577.0, 577.1) in a client: <ul style="list-style-type: none"> 1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; <i>or</i> 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours. 	610	Eye Exam/Refraction - Due to loss or breakage: For adults within 2 years of last exam when no medical indication exists and both of the following are documented in the client's record: <ul style="list-style-type: none"> 1) Glasses that are broken or lost or contacts that are lost or damaged; and 2) Last exam was at least 18 months ago. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Note: You do not need an EPA # when billing for children or clients with developmental disabilities. </div>


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Code	Criteria	Code	Criteria
Dispensing/Fitting Fees for Glasses CPT: 92340-92342		620 Flexible Frames for adults and children - when the following is documented in the client's record:	
615	<p>Glasses (both frames and lenses) – Due to loss or breakage for adults - within 2 years of last dispensing glasses may be replaced when glasses are broken or lost and all of the following are documented in the client's record:</p> <ol style="list-style-type: none"> 1) Copy of current prescription (less than 18 months old); and 2) Date of last dispensing; and 3) Both frames and lenses are broken or lost. <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	<ol style="list-style-type: none"> 1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. 	
Dispensing/Fitting Fees for Frames Only CPT: 92340, 92341, 92342		Dispensing/Fitting Fees for Lenses Only CPT: 92340 - 92342	
618	<p>Replacement Frames –Due to loss or breakage: For adults - lost or broken frames may be replaced when all of the following are documented in the client's record:</p> <ol style="list-style-type: none"> 1) No longer covered under the manufacturer's 1 year warranty; and 2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) and 3) Documentation of broken or lost frames. <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>	623	<p>Replacement eyeglass lenses – Due to loss or breakage: For adults, lost or broken lenses may be replaced when all of the following are documented in the client's record:</p> <ol style="list-style-type: none"> 1) Copy of current prescription (prescription is less than 18 months old); and 2) Date of last dispensing (if known); and 3) Documentation of lens damage or loss. <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p>
619	<p>Durable Frames for adults and children - when the following is documented in the client's record:</p> <ol style="list-style-type: none"> 1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. 	622	<p>Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision: For adults and children - within 2 years of last dispensing when:</p> <ol style="list-style-type: none"> 1) The client has a stable visual condition (see Definition section); and 2) The client's treatment is stabilized; and 3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; and 4) The previous and new refraction must be documented in the client record.




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Code	Criteria	Code	Criteria
624	<p>Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work: For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when all of the following are documented in the client's record:</p> <ol style="list-style-type: none"> 1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; and 2) Copy of current prescription (prescription is less than 18 months old for adults); and 3) Date of last dispensing, if known; and 4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); and 5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye. 	621	<p>Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision: For adults - within 1 year of last dispensing when:</p> <ol style="list-style-type: none"> 1) The client has a stable visual condition (see Definition section); and 2) The client's treatment is stabilized; and 3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; and 4) The previous and new refraction are documented in the client record. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>
625	<p>High index eyeglass lenses for adults and children when one of the following is documented in the client's record:</p> <ol style="list-style-type: none"> 1) A spherical refractive correction of +/- 8.0 diopters or greater; or 2) A cylinder correction of +/- 3.0 diopters or greater. 		
<p>Dispensing/Fitting Fees for Contacts CPT: 92070, 92310-92317</p>			
627	<p>Replacement Contact Lenses – Due to loss or breakage: For adults - once every 12 months when contact lenses are lost or damaged and the prescription is less than 18 months old.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Note: You do not need an EPA # when billing for children or clients with developmental disabilities.</p> </div>		
			<p>Blepharoplasties CPT: 15822, 15823, and 67901-67908,</p>
		630	<p>Blepharoplasty for noncosmetic reasons when <i>both</i> of the following are true:</p> <ol style="list-style-type: none"> 1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; 2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.
			<p>Strabismus Surgery CPT: 67311-67340</p>
		631	<p>Strabismus surgery for clients 18 years of age and older when <i>both</i> of the following are true:</p> <ol style="list-style-type: none"> 1) The client has double vision; and 2) It is not done for cosmetic reasons.

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Code	Criteria	Code	Criteria
Physical Therapy		Orthotics	
CPT: 97010-97150, 97520-97537, 97750		HCPCS: L3000	
640	An additional 48 Physical Therapy program units when the client has already used the allowed program units for the current year and has one of the following surgeries or injuries: 1) Lower Extremity Joint Surgery; 2) CVA not requiring acute inpatient rehabilitation; or 3) Spine surgery.	784	Foot insert, removable, molded to patient model, “UCB” type, Berkeley Shell, each Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met: 1) Required to prevent or correct pronation; 2) Required to promote proper foot alignment due to pronation; or 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.
641	An additional 96 Physical Therapy program units when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.	<div>Note: 1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 1-800-292-8064. 2) EPA is allowed only one time per client, per 12-month period. It is the provider’s responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria. 3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.</div>	
Occupational Therapy			
CPT: 97110, 97112, 97150, 97520, 97530, 97532, 97533, 97535, 97537		HCPCS: L3030	
644	An additional 12 Occupational Therapy visits when the client has used the allowed visits for the current year and has one of the following: 1) Hand\Upper Extremity Joint Surgery; or 2) CVA not requiring acute inpatient rehabilitation.	780	Foot insert, removable, formed to patient foot. One (1) pair allowed in a 12-month period if one of the following criteria is met: 1) Severe arthritis with pain; 2) Flat feet or pes planus with pain; 3) Valgus or varus deformity with pain; 4) Plantar facitis with pain; or 5) Pronation.
645	An additional 24 Occupational Therapy visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.		

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Code	Criteria	Code	Criteria
 <p>NOTE:</p> <ol style="list-style-type: none"> 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 1-800-292-8064. 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria. 		<p>HPCPS: L3215 or L3219</p> <p>785 Orthopedic footwear, woman's or man's shoes, oxford.</p> <p>Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:</p> <ol style="list-style-type: none"> 1) When one or both shoes are attached to a brace; 2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts; 3) To accommodate a partial foot prosthesis; or 4) To accommodate clubfoot. 	
<p>HPCPS: L3310 & L3320</p> <p>781 Lift, elevation, heel & sole, per inch.</p> <p>Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.</p> <p>HPCPS: L3334</p> <p>782 Lift, elevation, heel, per inch</p> <p>Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.</p>		 <p>NOTE:</p> <p>MAA does not allow orthopedic footwear for the following reasons:</p> <ol style="list-style-type: none"> 1) To accommodate L3030 orthotics; 2) Bunions; 3) Hammer toes; 4) Size difference (mismatched shoes); or 5) Abnormal sized foot. 	
 <p>NOTE:</p> <ol style="list-style-type: none"> 1) Lifts are not covered for less than one (1) inch. 2) Lifts are only allowed on one (1) pair of client shoes. 3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see <i>Important Contacts</i>) or by calling the authorization toll-free number at 1-800-292-8064. 4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria. 			

MAA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650, WAC 388-531-0700, and WAC 388-531-1600]

The following services must be performed in an MAA-approved Center of Excellence (COE) and **do not require prior authorization**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants;
- Inpatient Chronic Pain Management; or
- Sleep studies (CPT codes 95805, 95807-95811), only allowed for ICD-9-CM diagnoses 780.51, 780.53, 780.57, or 347 and Bariatric Surgery



Note: When billing on a paper HCFA-1500 claim form, note the COE in field 32. When billing electronically, note the COE in the *Comments* section.

MAA-Approved Organ Transplant Centers of Excellence (COE)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Medical Center/Seattle	<ul style="list-style-type: none"> • Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242 • 33945 • 47135-47136 • 50360, 50365, 50380
Dorenbacher Children's Hospital/Portland NW Marrow Transplant Program (PSC-T only)	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
Fred Hutchinson Cancer Research Center/Seattle	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
Good Samaritan Hospital Medical/Puyallup	<ul style="list-style-type: none"> • PSC-T 	<ul style="list-style-type: none"> • 38205-38206, 38240-38242
Inland NW Blood Center	<ul style="list-style-type: none"> • PSC-T 	<ul style="list-style-type: none"> • 38205-38206, 38240-38242
Legacy Good Samaritan Hospital/Portland (Northwest Marrow Transplant Program)	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
Mary Bridge Children's Hospital/Seattle	<ul style="list-style-type: none"> • PSC-T (autologous only) 	<ul style="list-style-type: none"> • 38206, 38242
Oregon Health Sciences University (OHSU)/Portland	<ul style="list-style-type: none"> • Heart • Liver • Kidney • Pancreas 	<ul style="list-style-type: none"> • 33945 • 47135-47136 • 50360, 50365, 50380 • 48160, 48554
Providence St. Peter Hospital/Olympia	<ul style="list-style-type: none"> • PSC-T 	<ul style="list-style-type: none"> • 38206, 38240-38242
Sacred Heart Medical Center/Spokane	<ul style="list-style-type: none"> • Kidney • Heart • Heart/Lung(s) • Lung 	<ul style="list-style-type: none"> • 50360, 50365, 50380 • 33945 • 33935 • 32851-32854
Seattle Cancer Care Alliance/Seattle	<ul style="list-style-type: none"> • BMT • PSC-T 	<ul style="list-style-type: none"> • 38230, 38240-38242 • 38205-38206, 38240-38242
St. Joseph's Hospital/Tacoma	<ul style="list-style-type: none"> • BMT (autologous only) • PSC-T 	<ul style="list-style-type: none"> • 38230, 38242 • 38205-38206, 38240-38242

MAA-Approved Organ Transplant Centers of Excellence (COE) (Cont.)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	<ul style="list-style-type: none"> • Kidney • PSC-T 	<ul style="list-style-type: none"> • 50360, 50365, 50380 • 38231, 38240-38241
University of Washington Medical Center/Seattle	<ul style="list-style-type: none"> • BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas 	<ul style="list-style-type: none"> • 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 33935 • 32851-32854 • 50360, 50365, 50380 • 47135-47136 • 48160, 48554
Virginia Mason Hospital/Seattle	<ul style="list-style-type: none"> • Kidney • Pancreas • BMT • PSC-T 	<ul style="list-style-type: none"> • 50360, 50365, 50380 • 48160, 48554 • 38230, 38240-38241 • 38231, 38240-38241

MAA-Approved Sleep Study Centers**[Refer to WAC 388-531-1500]**

MAA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Columbia Sleep Lab	Richland, WA.
Diagnostic Sleep Disorder Program Center	Children's Hospital and Medical - Bellevue, WA
Eastside Sleep Disorder Clinic	Overlake Hospital Medical Center - Bellevue, WA
Highline Sleep Disorders Center	Highline Community Hospital - Seattle, WA
Holy Family Sleep Disorder Center	Holy Family Hospital -Spokane, WA
Kathryn Severyns Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
Multi Care Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital - Tacoma, WA
Olympic Medical Center—Sleep Center	Olympic Medical Center Port Angeles, WA
Providence Everett Sleep Disorder Center	Providence Everett Medical Center - Everett, WA.
Richland Sleep Lab/Center	Richland Sleep Center – Richland, WA
Sleep Center at Memorial	Yakima Memorial Hospital – Yakima, WA
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorders Center Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center of Harrison Hospital	Harrison Hospital - Bremerton, WA
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Related Breathing Disorders Laboratory St Clare Hospital	St. Clare Hospital - Tacoma, WA
Sleep Studies Laboratory Mid Columbia Medical Center	Mid Columbia Medical Center - Dalles, OR
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID

Physician-Related Services

MAA Approved Sleep Centers	Location
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5 th Suite 400 W - Spokane, WA
University of Washington Sleep Disorders Center\Harborview Medical Center	Harborview Medical Center - Seattle, WA
Valley Medical Center--Sleep Center	Valley Medical Center Renton, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.
- Enter the location of the approved sleep center where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of MAA-approved sleep center.) Enter the information into the *Comments* section of the claim form.



Note: All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57**, or Narcolepsy **347.00-347.11**.

MAA-Approved Inpatient Pain Clinics

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

MAA-Approved Hospitals for Bariatric Surgery

MAA covers medically necessary bariatric surgery in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. Prior authorization is required. To begin the authorization process, providers should fax MAA a completed "Fax/Written Request Basic Information" form [DSHS # 13-756] to:

MAA – Division of Medical Management
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471